allergieambulatorium rennweg

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MEDICAL QUESTIONNAIRE

Dear patient!

Have you been here before? Please let us know at reception.

Patient data Date: .....

NAME: .....

Date of birth: ..... Health Insurance number: ..... Insurance company: .....

Phone:.....

FAX: ..... e-mail: .....

Address: ..... Postal code: ..... City: .....

Learned occupation: ..... Present occupation: .....

Working address:

If the patient is co-insured – **data of the insured person**:

NAME: .....

Date of birth: ..... Health Insurance number: ..... Insurance company: .....

Working address: .....

- Have you already undergone an **allergy-testing**?
  - ❍ No
  - ❍ Yes, **where:** ....., **when**: .....

  The following **allergies were found**:

  .....

- Since when do you have the symptoms? Since ..... days ..... months ..... years

- Reasons for coming here:

❍ **Eyes:**	❒ itching	❒ weep	❒ drought	❒ eyelid swelling
❍ **Nose:**	❒ itching	❒ sneeze	❒ stuffy nose	❒ nasal drip
❍ **Skin:**	❒ itching	❒ rash	❒ swellings	
❍ **Bronchia:**	❒ Asthma	❒ breathlessness	❒ nocturnal cough	

  ❍ **others**: which ones: .....

- Is there any connection to the time of the day (when is it worst)?
  ❍ in the morning ❍ at midday ❍ in the evening ❍ at night ❍ all day

- Is there any season, when it is worst: ❍ spring ❍ summer ❍ autumn ❍ winter ❍ all year

❍ months (from/to): .....

- Symptoms are worst:
  ❍ in the open air ❍ at workingplace ❍ at home
  ❍ after consumption of certain food: .....
- Do you take any **allergy-medication at present**? Which?

  .....
- Do you take any medication on a regular basis? (high blood-pressure, thyroid, glaucoma,..)
  ❍ No
  ❍ Yes, namely: .....
- Did you ever have severe symptoms in connection with

  Food:
  ❍ No
  ❍ Yes, which one: .....

  Bee stings: ❍ Yes ❍ No **Wasp stings**: ❍ Yes ❍ No
  ❍ local at the puncture site
  ❍ rash away from the puncture site or entire body ❍ difficulty in breathing ❍ circulatory issues

  PLEASE NOTE: If **yes**, please ask for the **bee and wasp sting questionnare** at the reception.
- Do you, or does anyone living with you, smoke? ❍ No, I don't
  ❍ Yes, at most ..... cigarettes a day
  ❍ Yes, I live in a smokers household
- Do you have any pet or frequent contact with animals? If yes, with which: .....
- Which problems do you have in contact with animals?
  ❍ None
  ❍ Yes, which: .....
- Do you have **plants** at your home or working place? ❍ Yes ❍ No
  Is it a ficus benjamini? ❍ Yes ❍ No
- Is your flat/house where you live infested with mould? ❍ Yes ❍ No
- Do you have in your bedding
  ❍ wild silk ❍ feathers ❍ sheep wool ❍ it is washable with 60°/90°
- Does anyone in you family suffer from an allergy (parents, siblings, grand parents)?
  ❍ No
  ❍ Yes, namely: .....
- Do you suffer from any other disease (e.g. high blood-pressure)?
  ❍ No
  ❍ Yes, namely: .....
- Are you currently pregnant: ❍ Yes ❍ No Are you breast-feeding? ❍ Yes ❍ No
- Did all your blood draws so far went well without problems (e.g. circulatory issues): ❍ Yes ❍ No

⇨ **NOTICE:** Your medical report will automatically be sent to your **referring physician** and your **home adress after all tests are completed and the results have been revised** (time may vary).

For mailing the report to your home adress, please pay € 0,70 at the reception to cover the postage.

⇨ **If required, you can get a time confirmation at the reception.**